STATE OF NORTH CAROLINA

COUNTY OF WAKE

IN THE OFFICE OF ADMINISTRATIVE HEARINGS

Optima Family Care of North Carolina, Inc., Petitioner, v. North Carolina Department of Health and Human Services, Mandy Cohen M.D., MPH in her official capacity as Secretary of the Department and Dave Richard in his official capacity as Deputy Secretary of the Department of NC Medicaid, Respondents, and WellCare of North Carolina, Inc., Blue Cross and Blue Shield of North Carolina, AmeriHealth Caritas of North Carolina, Inc., Carolina Complete Health, Inc., Respondent-Intervenors.	19-DHR-01959
North Carolina Provider Owned Plans, Inc., d/b/a My Health by Health Providers, Petitioner, v. North Carolina Department of Health and Human Services, Respondent, and UnitedHealthcare of North Carolina, Inc., Blue Cross and Blue Shield of North Carolina, WellCare of North Carolina, Inc., AmeriHealth Caritas of North Carolina, Inc., Carolina Complete Health, Inc., Respondent-Intervenors.	19-DHR-02032

Aetna Better Health of North Carolina Inc. d/b/a Aetna Better Health of North Carolina, Petitioner, v. State of North Carolina Department of Health and Human Services, Respondent, and WellCare of North Carolina, Inc., Blue Cross and Blue Shield of North Carolina, AmeriHealth Caritas of North Carolina, Inc., UnitedHealthcare of North Carolina, Inc., Carolina Complete Health, Inc., Respondent-Intervenors.	19-DHR-02194
Carolina Complete Health, Inc., Petitioner, v. North Carolina Department of Health and Human Services, Respondent.	19-DHR-03352

AETNA BETTER HEALTH OF NORTH CAROLINA INC.'S AMENDED PETITION FOR A CONTESTED CASE HEARING

NOW COMES Aetna Better Health of North Carolina Inc. ("**Petitioner**" or **"Aetna"**), by and through its undersigned attorneys, and hereby respectfully requests a contested case hearing pursuant to N.C. Gen. Stat. § 150B-23 against the North Carolina Department of Health and Human Services (**"Respondent"** or the **"Department"**). Specifically, Petitioner is challenging the Department's award of four statewide contracts for Medicaid managed care services pursuant to RFP #30-190029-DHB for Prepaid Health Plan Services issued on August 9, 2018 (the "**RFP**"), and its final decision denying Aetna's timely and well reasoned Protest

challenging the same. In support of this Petition, Aetna states the following:

I. INTRODUCTION

1. The Department's cavalier and unlawful approach to the procurement at issue makes the reason for this contested case simple — (1) the Department unilaterally manipulated the scoring to ensure that its favored Offeror, Blue Cross and Blue Shield of North Carolina, (hereinafter, "**BCBS**") would receive an award; (2) the shifting scoring methodology used by the Evaluation Committee was inherently flawed; and (3) the Evaluation Committee members failed to disclose certain conflicts of interest and, even when conflicts were disclosed, the Department simply swept them under the rug.

2. In making its award for a contract that is the largest in the history of state government and provides healthcare needs to at least 1.6 million of North Carolina's citizens, the Department abused its discretion and used a subjective, biased and arbitrary scoring methodology in violation of North Carolina procurement law. The decision was ultimately made by an Evaluation Committee that, at worst, had unredeemable conflicts or at best operated under an appearance of impropriety.

3. The State of North Carolina's Medicaid program and its beneficiaries, who are among this State's most vulnerable and needy citizens, deserve to have the most qualified and experienced managed health care providers delivering the services.

4. Aetna scored the highest of all Offerors in the Qualifications/Experience Section of the Department's RFP and earned the opportunity to serve the State's Medicaid beneficiaries − before the Department surreptitiously and unceremoniously manipulated the Evaluation Committee's scoring to allow BCBS to replace Aetna.

5. Under the guise of an unsolicited, unplanned and unconventional "Quality Assurance" review of the Offerors' references − and eleven meetings after the Department had

already affirmatively determined not to score the self-serving reference of BCBS by another BCBS entity − the Department's Deputy General Counsel unilaterally advised the Evaluation Committee on January 18, 2019 that it should reconsider and score the unqualified BCBS reference because it "appeared similar" to one of Aetna's references, which is entirely unfounded and incorrect.

6. If this were not enough, the Department advised the Evaluation Committee to re-score the non-compliant BCBS reference immediately ***after*** learning how the Offerors had been scored and knowing that the additional points from this invalid reference would place BCBS into the winning circle and Aetna out of contention for the award of a contract.

7. In sum, after learning that the Department's favored Offeror BCBS was not in the top four to receive an award of a Medicaid contract, and after receiving the Department's counsel's advice to score an already deficient reference, the Evaluation Committee backtracked and scored the BCBS reference it found by "consensus" only a month earlier to be deficient and ineligible for scoring. Accordingly, Aetna was denied the award of a statewide contract by a mere razor-thin margin of 2.06 points, just 0.2 percent of the total possible points by a conflicted Evaluation Committee.

8. On February 4, 2019, the Department adopted the purported recommendation of the Evaluation Committee with respect to the statewide awards, as manipulated following Department counsel's intervention, and announced the results on its website. On March 5, 2019, Aetna timely submitted to the Department its *Notice of Protest, Request for Protest Meeting, and Request for Stay*, attached hereto as **Exhibit A** (the **"Protest Letter"**).

9. A Protest Meeting with Aetna was held on April 4, 2019. On April 12, 2019, the Department issued its final decision in a letter from Susan Perry-Manning, Principal Deputy

Secretary for the Department, attached hereto as **Exhibit B** (the "**Protest Decision**"), which denied Aetna the relief to which it is entitled and again never mentioned that Aetna had scored in the top four before the Department counsel's manipulation and new scoring.

10. Aetna has exhausted its administrative remedies and has filed this Contested Case requesting that Aetna is properly included in the top four statewide Offerors or, in the alternative, requiring the Department to immediately issue a re-procurement to remedy the issues raised in this Contested Case.

11. To avoid market and member confusion while a decision on the final awards remains pending, Aetna further requests preliminary and permanent injunctive relief staying the award and/or implementation of all PHP contracts during the pendency of these and any further proceedings that may be had with respect to this Contested Case.

II. PARTIES

12. Petitioner Aetna is a health management organization duly authorized and incorporated under the laws of the State of North Carolina, with its principal office at 2801 Slater Road, Suite 200, Morrisville, North Carolina 27560, and was formed to engage in the business of providing Medicaid managed care services to the citizens of the State of North Carolina.

13. Defendant North Carolina Department of Health and Human Services is a State administrative agency with responsibility for the administration of the North Carolina Medicaid Program and is authorized to enter into contracts with Prepaid Health Plans to deliver Medicaid managed care services to the citizens of North Carolina pursuant to the RFP.

III. JURISDICTION AND VENUE

14. This Petition is timely filed pursuant to the North Carolina Administrative Procedure Act, N.C. Gen. Stat. § 150(B)-23, as a contested case challenging the final decision of

the Department issued on April 12, 2019, denying Aetna's Protest, upholding the Department's awards, and refusing to stay the implementation of the awards. *See* Protest Decision, Exhibit B.

15. This Contested Case is ripe for judicial review pursuant to N.C. Gen. Stat. § 150B-43, as Aetna is aggrieved by the final decision of the Department and has exhausted all administrative remedies made available to it.

16. Moreover, pursuant to N.C. Gen. Stat. §150B-33(b)(6), the action of the Department in upholding the underlying awards and refusing to stay the implementation of the awards can and should be stayed pending the outcome of this case, on such terms as are deemed proper, and subject to the provisions of N.C. G.S. 1A-1, Rule 65.

17. The proper venue for the hearing of this contested case is Wake County pursuant to N.C. Gen. Stat. §150B-24(a)(2).

IV. FACTUAL BACKGROUND

A. The RFP.

18. In 2015, the North Carolina General Assembly enacted Session Law 2015-245, directing the transition of Medicaid from a predominantly fee-for-service structure to managed care, a process that has been referred to as Medicaid transformation.

19. Under managed care, the Department will remain responsible for all aspects of the Medicaid and NC Health Choice programs. However, the direct management of health services and financial risks will be delegated to Prepaid Health Plans (**"PHPs"**), which will contract with health care providers to deliver services to their members.

20. From 2015 to 2018, after certain amendments to the original authorizing legislation had been enacted, on August 9, 2018, the Department issued its Request for Proposal #30-190029-DHB, for Medicaid Managed Care Prepaid Health Plans (the **"RFP"**).

21. Pursuant to Session Law 2015-245, as amended, the RFP sought proposals for capitated contracts with two types of entities: Commercial Plans (**"CPs"**) and Provider-Led Entities (**"PLEs"**), collectively referred to as PHPs.

22. The scope of the delegation to PHPs is quite broad and requires deep and extensive experience to ensure that members receive proper care and coverage, as the Department will be delegating to PHPs direct management of physical health, behavioral health and pharmacy services, and financial risks.

23. The PHPs will receive a monthly, actuarially sound, capitated payment and will contract with providers to deliver health services to their Members.

24. Once Medicaid Managed Care is launched, most North Carolina Medicaid and NC Health Choice populations will be mandatorily enrolled in PHPs.

25. Section 4.(6) of Session Law 2015-245, as amended by Session Law 2016-121 and Session Law 2018-48, required the Department to award four (4) statewide contracts and up to twelve (12) regional contracts (with the state being divided into six regions).

26. The Department was authorized to contract with either CPs or PLEs for statewide contracts, but could only contract with PLEs for regional contracts.

27. As Aetna is a CP within the meaning of the RFP, and was thus only eligible for a statewide contract, this Contested Case only concerns the Department's award of the four (4) statewide contracts and not the regional contracts which were solely available for PLEs.

28. The defects and errors identified herein and which establish that the existing awards, in excluding Aetna, are unlawful, unsupported by the evidence, arbitrary and capricious, and the result of an abuse of discretion, are unique to Aetna, as distinguished from the three (3) PLEs that separately submitted Protests to the Department.

B. The Conflict of Interests.

29. The Department has a statutory obligation to ensure a fair, competitive bidding environment for all Offerors.

30. The competitive procurement process required that the Department ensure that the process operated in a fair and equitable manner and that those who are part of the process on behalf of the Department maintained the ethics and integrity of the procurement process.

31. In doing so, the Department required those scoring and non-scoring members of the procurement process on behalf of the Department to execute a Request for Information Confidentiality and Conflict of Interest Statement ("Conflict of Interest Statement").

32. The Conflict of Interest Statement, a copy of which is attached here as **Exhibit C**, provides in pertinent part:

> **Conflicts of Interest**. A Conflict of Interest, or the appearance of a Conflict of Interest, may occur if you are directly or indirectly involved with a person or an organization that has submitted a proposal for evaluation.
>
> 1. A Conflict of Interest includes, but is not limited to, the items stated below.
>
> i. *Socialization with Vendors, Contractors or Potential Respondents.* As an evaluator, you may not participate in social activities with vendors, contractors, potential respondents, or other entities that may interfere with the proper performance of your duties and responsibilities as a member of the Committee. Any activity that would appear to a reasonable person to undermine the independence, integrity or impartiality as an evaluator must be avoided.
>
> If a Committee Member participates in a social activity described above, or has a close personal relationship with a vendor, contractor or potential respondent, the Committee Member shall promptly notify the Contract Lead(s).
>
> ii. *Financial Conflicts of Interest.* A Financial Conflict of Interest is where the potential exists for a Committee Member's personal financial interests, or for the personal financial interests of an

immediate family member, to influence, or have the appearance of influencing, your judgment in the performance of your duties and responsibilities as a Committee Member.

To preserve the integrity of the procurement process, a Committee Member may not take part in activities and decisions for the associated procurement:

a) Relating to you or any member of your immediate family; or
b) Relating to any entity in which your or any member of your immediate family are an officer, director or partner; or
c) Relating to any entity in which you or any member of your immediate family works for or performs services to a vendor, contractor or respondent has submitted a proposal.

iii. *Personal Relationships, Favoritism, and Bias Participation.* Committee Members are prohibited from participating in all discussions or decisions relating to the associated procurement if they have any type of personal relationship, favoritism, or bias that would appear to a reasonable person to influence their independence in performing their assigned duties and responsibilities in a fair and objective manner.

33. Under the Conflict of Interest Statement, prior to reviewing any proposals, those participating in the procurement at issue were obligated to inform the Department "of any Conflict or potential Conflict of interest."

34. Indeed, each meeting (and there were purportedly over 46 meetings) of the Evaluation Committee started with an affirmation that the members and those working with them were compliant with the Conflict of Interest Statement and that each of them had no new conflict to report.

35. The Department and its scoring and non-scoring members failed to abide by the Department's own Conflict of Interest Statement by failing to report. For example:

a. One of the scoring members of the Evaluation Committee currently, and during the procurement, dates and lives with an employee of **BCBS** who works as the Director of Healthcare Strategy and Transformation for BCBS.

b. An Evaluation Committee Member had significant personal financial

issues necessitating court filings during her time on the Evaluation Committee and, immediately after the procurement was scored, she accepted a position with **BCBS** making more money than she did with the Department.

c. An Evaluation Committee member who scored the bids and a non-scoring member who designed the RFP had previously been employed by **BCBS**.

d. The Department's counsel and COO have both worked extensively with **BCBS** throughout the course of their careers with the Department.

36. While some of these instances were reported to the Department and upper level management, many conflicts or potential conflicts were not. Of those that were reported, the Department undertook no formal or informal action to protect the integrity of the process or to ensure that these inherent conflicts of interest were addressed, which created an even deeper appearance of impropriety. Instead, each of the individuals with conflicts of interest were able to serve on or for the Evaluation Committee and participate in the underlying process without following the Department's own procedures or further implementing safeguards to mitigate potential conflicts.

C. The Evaluation Process.

37. On October 19, 2018, the Department opened Proposals from eight Offerors, including Aetna and four other CPs: BCBS, UnitedHealthcare of North Carolina, Inc. ("**UHC**"), AmeriHealth Caritas of North Carolina, Inc. ("**AmeriHealth**"), and WellCare of North Carolina, Inc. ("**WellCare**"); and three PLEs: Carolina Complete Health ("**CCH**"), Optima Family Care of North Carolina, Inc. ("**Optima**"), and My Health by Health Providers ("**My Health**").

38. On January 18, 2019, the "Contracts Team" for the Department, which included Kimberley Kilpatrick and Gregory Sligh, (who were charged with leading the Evaluation Scoring members) along with the Department's COO Mona Moon and Deputy General Counsel

Lotta Crabtree, disclosed to the Evaluation Committee the actual ranking of the Offerors as the scoring process had come to a close.

The scoring was presented as follows:

Highest Scoring Offer, Ranked 1st	731.99304	71.414%

					Difference vs Ranked 1st		Difference vs. Next Highest	
	Offeror Name	Weighted Total Score	Percentage of Total Possible Points	Rank	# Points	% Points		
Statewide	WellCare Health Plans	731.99304	71.414%	1	0.00000	0.000%	0.00000	0.000%
Statewide	United Health Care	727.57415	70.983%	2	-4.41889	-0.431%	-4.41889	-0.431%
Statewide	AmeriHealth Caritas North Carolina	711.25579	69.391%	3	-20.73725	-2.023%	-16.31836	-1.592%
Statewide	Aetna	704.60144	68.742%	4	-27.39160	-2.672%	-6.65436	-0.649%
Statewide	BCBSNC – Healthy Blue	700.15931	68.308%	5	-31.83373	-3.106%	-4.44212	-0.433%
Statewide	My Health by Health Providers	629.11280	61.377%	6	-102.88024	-10.037%	-71.04652	-6.931%
Either	Carolina Complete Health	612.64969	59.771%	7	-119.34335	-11.643%	-16.46311	-1.606%
Regional	Optima Health	573.48539	55.950%	8	-158.50765	-15.464%	-39.16430	-3.821%

Total Possible Score	1025.00000
Total Possible If All Scores Meet Expectations (60%)	615.00000

39. Aetna was in the top four of all Offerors, but, remarkably, the record created and ultimately provided by the Department in the PHP Evaluation Committee Meeting Notes and Timeline failed to identify Aetna in the top four. Indeed, the above scoring was never produced to the Offerors or identified anywhere in the record provided herein. Not surprisingly, albeit improperly, the Department failed to mention or produce the above scoring until after one of the Department's witnesses referenced it under cross-examination during her deposition testimony − to wit, the above scoring identifying Aetna in the top four was withheld and not produced until this Petitioner unearthed and demanded its production even though it was responsive to public records and discovery requests.

40. On this same day, January 18, 2019, the Evaluation Committee completed its only quality assurance review by ensuring the scores of the Exceeds/Substantially Exceeds ratings by the Evaluation Committee were properly documented and sufficiently detailed. The Evaluation Committee completed the same review for the Partially Meets/Does not Meet ratings on January

15, 2019 along with the Contracting Team.

41. Significantly, there is no written, documented or identifiable Quality Assurance program mentioned, identified or provided for in the RFP, the Administrative Code or Department manual. Nevertheless, on January 18, 2019, the Department advised the Evaluation Committee *for the first time* that there would be an additional step in the process. "The next step of the quality assurance process is for [the Department's Deputy General Counsel] Lotta Crabtree to review the scoring of Offeror Client References."

42. There is conveniently no record of what Ms. Crabtree reviewed, considered or actually reasoned. In fact, the record suggests that the only Offeror Client Reference that was reviewed by Ms. Crabtree was the BCBS reference that the Evaluation Committee had previously decided a month earlier by "consensus" not to score.

43. However, on January 22, Ms. Crabtree advised the Evaluation Committee that the reference submitted by BCBS "appeared similar" to one of Aetna's references. Accordingly, Ms. Crabtree recommended − after the scores were already calculated and finalized in accordance with the RFP − that the Evaluation Committee score the BCBS reference.

44. When the Evaluation Committee was requested to reconsider the BCBS reference, it did not have, did not compare and were not provided any documents. The references themselves that the Evaluation Committee were being advised to reconsider had been reviewed eleven meetings earlier and over a month before this January 22 meeting. The references were never re-examined by the Evaluation Committee before they abandoned their consensus and introduced a new score for BCBS' reference. The Evaluation Committee's decision to re-score was premised solely upon Ms. Crabtree's direction and purported finding that the references "appeared similar."

45. Neither the Department nor its Evaluation Committee members have been able to articulate the rationale or provide any detail regarding its decision to reconsider the Evaluation Committee's original consensus decision not to provide any points to BCBS on the reference at issue.

46. The Department has not allowed any witness to address or disclose: (1) the analysis or recommendation of Ms. Crabtree; (2) the communications relating to the scoring of the BCBS reference; and (3) the communications relating to the last minute "quality assurance" conducted by Ms. Crabtree premised upon the purported "attorney/client privilege." However, Ms. Crabtree was not providing legal advice and was also designated as a Subject Matter Expert by the Department and was part of the Evaluation Committee, providing business advice.

47. The fact that the record is not transparent and devoid of the manner in which the Department unilaterally manipulated the scoring speaks volumes.

48. Based on the revised scoring that was publicly announced, the margin between Aetna, which was ranked in fifth place for a statewide plan, was indisputably narrow. Aetna was a mere 2.06 points behind fourth-place finisher AmeriHealth and BCBS leapfrogged into third place:

Offeror Name	**Weighted Total Points**
WellCare Health Plans	736.19304
United Health Care	727.76474
BCBS - Healthy Blue	712.22431
AmeriHealth Caritas North Carolina	706.66204
Aetna	704.60144

49. The Department's bias in scoring is so obvious that one can only conclude that the outcome was preordained and that the scoring process and unilateral and unprecedented "quality assurance" for references were utilized to accomplish a desired outcome.

50. Because of this narrow margin, even a modest scoring error − which there were

plenty − alters the results to Aetna's unfair prejudice.

51. Without knowing of the manipulated scoring, the Department's failure to disclose the same, or inherent conflict of interests on the inadequate record made available by the Department, Aetna still identified significant errors and defects in the evaluation and scoring of Aetna and others Proposals.

52. Even if one were to somehow ignore the Department's blatant manipulation and collusion, the correction of just some of these additional scoring errors and issues alone ranks Aetna second overall, and thus entitle Aetna to a statewide contract pursuant to the RFP.

D. Aetna's Protest.

53. Because of the scoring errors and disclosure issues identified from a review of the incomplete records produced by the Department following the announcement of the awards, on March 5, 2019, Aetna timely submitted to the Department its Protest Letter. (*See* Ex. A).

54. As set forth in its Protest Letter and this Petition, Aetna raises significant and serious errors and issues with the awards announced on February 4, 2019, that renders the awards, among other things, unlawful, unsupported by the evidence, arbitrary and capricious and the result of an abuse of discretion.

55. The resulting defects in the awards fell within the categories outlined in the Protest Letter and this Petition, including that:

(1) The scores of BCBS were unilaterally manipulated by the Department to ensure that the Department's most favored Offeror remained as a provider for the State;

(2) Aetna did not receive proper credit for responsive answers to RFP questions, as measured against similar, less complete, or inadequate answers provided by other Offerors. The correction of these errors results in Aetna being in the top four statewide Offerors, irrespective of the need to adjust other Offerors' scores

downward or address grounds for the disqualification of other Offerors;

(3) AmeriHealth was improperly awarded points for inadequate and incomplete answers to RFP questions, that, if corrected, are in and of themselves sufficient to place AmeriHealth outside of the top four statewide Offerors and Aetna into the top four Offerors; and,

(4) WellCare's proposal is flawed and should be disqualified because it noticeably failed to disclose sanctions imposed within the last seven (7) years, and also failed to disclose corrective actions taken to prevent any future occurrences of the problems that led to those sanctions, all as required by Question 10 of the RFP.

1. Aetna Did Not Receive Proper Credit for Responsive Answers.

56. As set forth in the Protest Letter, the Evaluation Committee, and ultimately the Department, failed to properly score Aetna's Proposal in a manner that renders the awards unlawful, arbitrary and capricious, unsupported by the evidence and the result of an abuse of discretion.

a. Aetna should be awarded an additional 2.16 points for its answer to Question No. 5, which would raise its total score to 706.76144.

57. As detailed at pages 4-6 of the Protest Letter, Question No. 5 requested Offerors to identify and provide information regarding vendors who would perform Core Medicaid Functions.

58. Notably, there were several components to Question No. 5 for which Aetna did not receive full credit for its answers, as can be objectively determined by reference to proposals that received higher scores for responses that were, at a minimum, the same or substantively indistinguishable from Aetna's responses.

59. Indeed, Aetna arbitrarily received less credit and lower scores than other Offerors for the exact same experience and even for using the exact same vendors, a defect that standing

alone renders the existing awards an abuse of discretion.

60. Critically, the corrections necessary to address the Committee's failure to properly score Aetna's Proposal with respect to Question No. 5 are, standing alone, sufficient to flip the award in favor of Aetna, as crediting Aetna with the same ranking and points for the same vendors and experience results in a cumulative net 2.16-point increase to Aetna's total score.

61. However, these errors are merely the tip of the iceberg, as it is apparent that the Evaluation Committee failed elsewhere to properly follow its own rules and apply criteria consistently across proposals.

b. Aetna should be awarded an additional 10.5 points for its answer to Question No. 46, which would raise its total score to 717.26144.

62. As further set forth in the Protest Letter, Question No. 46 required Offerors to describe their experience with Value Based Payments/Alternative Payment Models, including: "A description of value-based payment arrangements the Offeror has used in up to 2 other locations (e.g., another state or region). …" [Emphasis added].

63. Aetna was unfairly prejudiced when the Evaluation Committee rewarded Offerors who violated these express instructions of Question No. 46 with additional points. The RFP could not have been clearer that the number of locations Offerors were permitted to discuss – two – was a ceiling, not a floor.

64. Aetna complied, even though, as a nationwide leader in value-based reimbursement, Aetna has numerous value-based contract arrangements that could have been shared in response to Question No. 46, but were not included because Aetna followed the instructions.

65. In contrast, as evidenced by the Department's scoring records, other Offerors simply ignored the Department's instructions, yet were rewarded for doing so.

66. For example, although its response is significantly redacted, AmeriHealth identified at least five (5) locations in its response (D.C., Louisiana, and Pennsylvania in Section A, and also identified Michigan and Florida in Section D), and was awarded a rating of "Exceeds" for its disregard.

67. Similarly, although BCBS also heavily redacted its response, it is evident from scoring records that it also flouted instructions by leveraging all twenty-two (22) of its Medicaid plans in its response, and likewise received a rating of "Exceeds."

68. Aetna, on the other hand, was punished for its compliance by receiving a rating of "Meets."

69. Had Aetna similarly disregarded instructions and relied on its experience in more than two locations, it would have readily been able to further demonstrate its entitlement to a rating of "Exceeds" or "Substantially Exceeds."

70. As its answer stands, Aetna already deserves a rating of at least "Exceeds" because of the quality of its two examples offered in adherence to the RFP's express ceiling. Aetna certainly should not be penalized for following the rules.

71. Accordingly, Aetna should at least receive an additional 10.5-point increase to its total score for its response to Question No. 46.

c. Aetna should be awarded an additional 4.59375 points for its answer to Question No. 48, which would raise its total score to 721.85519.

72. As further addressed in the Protest Letter, Question No. 48 required Offerors to describe their approach to meeting the Department's expectations and requirements with respect

to Engagement with Community and County Organizations.

73. Despite providing a clearly superior response to WellCare, Aetna arbitrarily received a rating of "Meets," while WellCare received a rating of "Exceeds."

74. Aetna's response to Question No. 48 is not only more robust and thoughtful, it is objectively superior to that of WellCare.

75. Notably, even the scoring members of the Evaluation Committee cannot identify a purported "strategic" difference between Aetna or any other Offeror who received a higher score.

76. Aetna met with 1,000 Community Based Organizations (CBOs) in all 100 counties in North Carolina throughout the past two (2) years, and:

- Partnered with Community Care of North Carolina, a known entity in all of the regions of the State
- Engaged in extensive efforts in North Carolina to tackle the opioid crisis
- Proposed a Community Health Worker Pilot
- Supported schools with Jobs for America's Graduates (JAG) program
- Provided monetary donations for hurricane relief and food insecurity
- Hosted focus groups that informed value adds
- Proposed co-location of staff in CBOs
- Proposed maintaining a housing specialist on staff at the plan to help with housing related issues

77. In contrast, WellCare met with only 200 CBOs, and:

- Talked about their proprietary Community for Impact Model - Community Advocate
- Provided monetary donations for hurricane relief
- Had a named North Carolina CEO
- Proposed local community relations workers
- Agreed to be on an advisory council

78. At a minimum, Aetna should receive a score equal to that of WellCare, resulting in a 4.59375-point increase in its total score.

d. Aetna should be awarded an additional 1.407 points for its answer to Question No. 56, which would raise its total score to 723.26219.

79. Question No. 56 required Offerors to confirm their "adherence and describe its approach to meeting the Department's expectations and requirements outlined in Section V.H.2 Encounters" and provide supporting documentation to include a Draft Encounter Implementation Approach.

80. Here, Aetna was assigned "0" points for "Supporting Documentation" on the Draft Implementation Approach for not specifically addressing items in Section V.K.6.c.

81. Question No. 56, however, requested that Offerors specifically respond to V.H.2, not V.K.6.c. Aetna nevertheless actually – and properly – addressed V.K.6.c elements in its Question No. 56 Narrative.

82. Aetna thus provided a complete and fulsome response to Question No. 56 and there was no basis for granting it "0" points for the Supporting Documentation Requirement.

83. Any reliance by the Evaluation Committee upon some unstated criteria is a patent example of an abuse of discretion and arbitrariness.

84. Because Aetna should at least receive a "Meets" rather than a "Does Not Meet" based on its full compliance with the stated criteria of Question No. 56, it should receive, at a minimum, an additional 1.407 points to its total score.

e. The corrections to Aetna's score, standing alone, place it in the top four statewide Offerors.

85. As demonstrated above, Aetna should receive a total of 18.66075 additional points. As a result, Aetna's total score should have been 723.26219, which would put it in the top four Statewide Offerors and thus entitled to the award of a statewide contract:

Offeror Name	Weighted Total Points	Corrected Weighted Total Points
WellCare Health Plans	736.19304	
United Health Care	727.76474	
Aetna	704.60144	**723.26219**
BCBS - Healthy Blue	712.22431	
AmeriHealth Caritas North Carolina	706.66204	

2. AmeriHealth Was Improperly Awarded Points for Inadequate and Incomplete Answers.

86. Fourth-place finisher AmeriHealth received scores for answers to RFP questions that were incomplete or facially inadequate, and if not corrected, lead to an arbitrary and capricious result.

87. When corrected, the corrections to the scoring of AmeriHealth's proposal provides both independent and cumulative grounds to place Aetna in the top four statewide Offerors and AmeriHealth in fifth place.

a. AmeriHealth's score for Question No. 50 should be reduced by 4.4625 points, which would reduce its total score to 702.19954.

88. Question No. 50 required each Offeror to "confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in Section V.G.1. Service Lines…"

89. AmeriHealth failed to confirm its adherence with the Department's expectations, yet received a higher score than Aetna which – in contrast to AmeriHealth – fully complied and confirmed its adherence.

90. Section V, Scope of Services, page 214, V.G. Table 1 expressly requires the Emergency Member issues service line to provide 24/7/365 coverage and be located in the State of North Carolina.

91. Significantly, complying with this requirement was a substantial undertaking to

which Aetna nevertheless committed, respecting the requirement that a North Carolina resident calling Aetna's service line would at all times be able to reach a North Carolina resident to assist them.

92. In contrast, AmeriHealth's proposal remarkably provides that their after-hours line will be located in Philadelphia, Pennsylvania – **not** North Carolina.

93. Despite this, in scoring Question No. 50, the Evaluation Committee rated AmeriHealth's response as "Exceeds," whereas Aetna's response was rated "Meets."

94. The Evaluation Committee arbitrarily and capriciously disregarded the Department's own express requirements, even though they have no authority to modify or change the requirements of the RFP.

95. Because AmeriHealth's response should be downgraded to "Does Not Meet," due to its failure to comply with the requirement that its service line be in the State of North Carolina, it should receive a 4.4625 reduction to its total score.

b. AmeriHealth's score for Question No. 62 should be reduced by 5.95 points, and its corresponding score for Question No. 5 and 9 should be reduced by 3.77723 and 20.0 points, respectively, which would reduce its total score to 672.47231.

96. Question No. 62 required each Offeror to "confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in Section V.J.3. Fraud, Waste and Abuse Prevention" and provide information that included "all Entities identified in Question #5 of the Offeror's Proposal and Response that are performing core functions or proposed experiences related to this response." (Emphasis in RFP).

97. In response to Question No. 62, AmeriHealth relied upon two vendors, Optum and Change Healthcare Coding Advisor, for which it failed to make necessary and critical disclosures, because it failed to identify or even recognize them as entities performing core

functions.

98. Even more troubling, it appears that the Department, in ruling on the Protest, also failed to recognize that these vendors perform core functions within the express meaning of the RFP, confirming that the Department's scoring was arbitrary and unsupported by the evidence.

99. As reflected in the bolded language of Question No. 62, that question requires Offerors to list all entities identified in Question No. 5 as performing core functions related to their responses to Question No. 62.

100. In its narrative response to Question No. 62, AmeriHealth disclosed the significant roles Optum and Change Healthcare Coding Advisor would have in monitoring payments and overpayments. These are a critical component of processing and paying claims, which includes preventing overpayments and thus Medicaid fraud, waste, and abuse.

101. The functions performed by these vendors thus fall squarely within the definition of Core Medicaid operations functions, which include processing and payment of claims in a manner that ensures payment integrity and minimizes incorrect claims payments.

102. Yet, AmeriHealth failed to disclose either of these vendors in response to Question No. 5, nor did they list either of these vendors at the outset of Question No. 62 as expressly required by the instructions.

103. As such, a reduction of AmeriHealth's score is warranted because:

(i) by failing to properly list these entities in Question No. 5 and Question No. 62, AmeriHealth's reliance on them in response to Question No. 62 should be disregarded, thereby rendering this response inadequate;

(ii) by failing to disclose these entities in the first place in response to Question No. 5, AmeriHealth failed to make required disclosures in that response necessary for the Department to fully and fairly evaluate AmeriHealth's Proposal; and,

(iii) by failing to disclose these entities in response to Question No. 5, AmeriHealth further failed to make complete disclosures as to these entities in response to Question No. 9.

104. Accordingly:

(i) with respect to Question No. 62, AmeriHealth received an equal score (5.95) ("Exceeds") to Aetna, UnitedHealthcare, and WellCare. Because its reliance on Optum and Change Healthcare Coding Advisor should be disregarded with respect to Question No. 62, AmeriHealth should be scored as "Does Not Meet" and awarded no points for its response to Question No. 62, resulting in a **5.95-point reduction** to its total score.

(ii) AmeriHealth's score for its response to Question No. 5 should be downgraded to "Does Not Meet" for these two entities as a result of failing to identify them as performing Core Medicaid functions and providing the information required of them by Question No. 5, resulting in an additional 3.77723-point reduction to its total score; and

(iii) in addition to the disclosures directly required by Section 5, other sections of the RFP required full disclosures from entities performing Core Medicaid functions, which AmeriHealth thus additionally and necessarily failed to address with respect to Optum and Change Healthcare Coding Advisor, including, without limitation, Question No. 9, resulting in an additional 20.0-point reduction to its total score.

105. Taken together, these scoring corrections should result in a 29.72723-point reduction in AmeriHealth's total score. Similar issues with respect to other portions of AmeriHealth's Proposal, which was subject to significant redaction, may warrant further reductions.

106. The Department's failure to make these corrections, and its failure to recognize the core functions performed by the entities disclosed by AmeriHealth, further renders its decision an abuse of discretion and unsupported by the evidence.

c. The corrections to AmeriHealth's score, standing alone, drop it below Aetna and therefore place Aetna in the top four statewide Offerors.

107. Standing alone, the correction of AmeriHealth's Score places Aetna in the top four statewide Offerors, and AmeriHealth in fifth place, unless WellCare is disqualified, in which case AmeriHealth remains eligible as the fourth-place finisher.

108. In addition to the issues discussed above, the granting of "bonus" points for AmeriHealth's "commitment" to participate in Qualified Health Plans in North Carolina on the Federally Facilitated Marketplace (the "FFM") improperly impacted the results by dictating that AmeriHealth could receive an award despite the fact that it placed fifth with respect to the RFP requirements that actually related to providing Medicaid managed care services.

109. Even without consideration of the improper effect of the bonus points, however, the corrections to AmeriHealth's score, when combined with the corrections to Aetna's score, unquestionably require an award of a contract to Aetna:

Offeror Name	**Weighted Total Points**	**Corrected Weighted Total Points**
WellCare Health Plans	736.19304	
United Health Care	727.76474	
Aetna	704.60144	**723.26219**
BCBS - Healthy Blue	712.22431	
AmeriHealth Caritas North Carolina	706.66204	**672.47231**

3. WellCare should have been disqualified.

110. In addition to failing to correct the serious scoring errors discussed above, the Department further abused its discretion by failing to disqualify WellCare and reject its Proposal based on WellCare's failure to disclose $137.5 million sanctions and related corrective actions as required by Question No. 10 of the RFP.

111. Question No. 10 of the RFP required Offerors to disclose sanctions imposed

within the last seven (7) years on Offerors, or entities performing core functions for Offerors, as part of managed care contracts, along with disclosure of corrective actions taken to prevent future occurrences of the problems that led to the sanctions.

112. In 2015, WellCare of Iowa, Inc. was disqualified from an award of an Iowa Medicaid Contract and its contract was terminated as a result of its failure to disclose events that WellCare once again improperly failed to disclose in response to the North Carolina RFP at issue, namely:

> (i) sanctions imposed by a $137.5 Million Settlement Agreement effective March 23, 2012 (attached to Markovich Affidavit as Exhibit 13; see ¶¶ 1, 31, and p. 29) between the United States, through the U.S. Department of Justice, certain quit tam Relators, and WellCare Health Plans, Inc. and various WellCare affiliates (including Comprehensive Health Care Management, Inc., identified in the present RFP as performing core functions for WellCare); and,
>
> (ii) (ii) corrective actions imposed on it by a Corporate Integrity Agreement (CIA) (attached to Markovich Affidavit as Exhibit 14).

113. The Settlement Agreement arose out of several lawsuits filed by Relators (as defined in the Settlement Agreement) against numerous WellCare affiliates pursuant to the qui tam provisions of the False Claims Act, 31 U.S.C. § 3730(b), which included claims relating to false claims submitted for payment to the Medicaid Program.

114. In ruling that WellCare should be disqualified, an Administrative Law Judge ("ALJ") in Iowa specifically concluded that:

> (i) the Settlement Agreement and the $137.5 million payment to resolve false claim litigation and avoid suspension from the Medicaid program was **"a penalty"** and **"a monetary sanction"** within the applicable look-back period; and,
>
> (ii) the CIA, in force through April 2016, required WellCare to take corrective actions to prevent repetition of past misconduct.

(*See* Iowa Department of Inspections and Appeals, Division of Administrative Hearings, Appeal Nos. 16001573, 16001590, 16001623, Proposed Decision, at pp. 41-42 (attached to Markovich Affidavit as Exhibit 16).

115. Because the ALJ in Iowa fittingly found that these sanctions and corrective actions were within the applicable look-back period, and WellCare failed to disclose them, the Iowa Department of Human Services accordingly determined that: "The Notice of Intent to Award is REVERSED as to WellCare of Iowa, Inc. and its contract with DHS is terminated." (See Final Decision, attached to Markovich Affidavit as Exhibit 15).

116. The Iowa Department's Final Decision, in turn, was upheld in the Iowa District Court of Polk County. See WellCare of Iowa, Inc., et al. v. Iowa Department of Human Services, Case No. CVCV051022, Ruling on Petition for Judicial Review, p. 13 (attached to Markovich Affidavit as Exhibit 17).

117. Similarly, here, WellCare indisputably failed to disclose the $137.5 million sanctions and the Corporate Integrity Agreement as corrective actions in response to Question No. 10 of the North Carolina RFP.

118. In response to Aetna's Protest Letter, WellCare submitted a response letter on March 19, 2019, effectively taking the position that because the $137.5 million payments were merely "voluntary," they were not really "sanctions."

119. Accordingly, not only did WellCare argue that it was not required to disclose the $137.5 million sanctions in response to Question No. 10, it even boasted of two misleading and cursory references to the 2012 Settlement Agreement as somehow going above and beyond its disclosure obligations. One of these references was buried in a different part of its Proposal and did not include the level of detail required by Question No. 10. The other was buried in attached

SEC filings responsive to an entirely unrelated section of the RFP regarding financial condition.

120. However, far from including passing references – in WellCare's words – in the "spirit of full disclosure," WellCare's cursory mischaracterization of the 2012 Settlement Agreement actually misled the Evaluation Committee as to the true nature of the Sanctions that had been imposed in that agreement.

121. Thus, there is absolutely no evidence that the Evaluation Committee understood, as it was reviewing WellCare's proposal, that it had been actively misled with respect to the fact that the $137.5 million sanction was, in fact, a sanction and that the corresponding Corporate Integrity Agreement constituted corrective actions, disclosure of which was also required by Question No. 10.

122. Nor did WellCare disclose that the question of whether the monetary penalty was a "sanction" was fully litigated in Iowa, by WellCare, and a final judgment by an Iowa Court of competent jurisdiction was entered, and was necessarily based on the finding that the $137 million payment imposed by the 2012 Settlement Agreement was, in fact, a sanction.

123. Moreover, as is also evident from the 2012 Settlement Agreement itself and the administrative and judicial proceedings in Iowa, the sanctions were not "voluntary." Rather, they were imposed to resolve false claims under contracts for Medicaid managed care services and so that WellCare would not be subject to exclusion from the Medicaid program and could thus continue performing under managed care contracts.

124. In short, WellCare is precluded from relitigating the question of whether the $137.5 million payments imposed by the Settlement Agreement were "voluntary" and therefore not sanctions, a rather farcical notion given that the payments were required by the U.S. government to avoid exclusion from the Medicaid program and continued participation in

Medicaid managed care contracts.

125. WellCare thus knew full well these were sanctions and should have fully disclosed them, along with all related corrective actions, in response to and as required by Question No. 10.

126. WellCare nevertheless inexcusably failed to disclose the $137.5 million sanction and related corrective actions, and its Proposal should have thus been rejected as misleading and incomplete.

127. Again, the fact that WellCare provided two misleading references to what it called the "2011 [SIC] Settlement Agreement" buried in different parts of its proposal is actually more misleading than a complete omission, because the Evaluation Committee was misled to believe the information was not responsive to Question No. 10, and thus could not have taken into account the impact of WellCare's nondisclosure on the credibility and reliability of its Proposal as a whole.

128. Pursuant to RFP § II.E.1.b, "Offeror's proposal must clearly demonstrate compliance with all the requirements stated within this RFP."

129. The Department similarly reserves the right to reject proposals deemed incomplete, non-responsive, or non-compliant with the RFP requirements; or when such rejection is deemed to be in the best interest of the Department or the State of North Carolina. Moreover, the failure to complete and return all documents and attachments as required in the RFP may result in disqualification. See RFP, § II.E.2.

130. Here, WellCare's nondisclosure and misleading conduct deprived the Evaluation Committee of the opportunity to exercise its discretion and fully evaluate these sanctions and corrective actions in connection with the RFP, and the Department compounded the error by

accepting WellCare's misleading response to Aetna's protest. Accordingly, the award of a contract to WellCare constitutes an abuse of discretion, and WellCare should be disqualified.

E. The Protest Meeting and the Department's Ruling.

131. In response to Aetna's Protest Letter, the Department designated Susan Perry-Manning, Principal Deputy Secretary for the Department, to act as the executive officer of the Protest, and held a Protest meeting on April 4, 2019.

132. At the Protest Meeting, which was conducted before a Court Reporter, Aetna was provided an opportunity to present its arguments, and a team of Department officials presented a defense of the Department's decision; however, Ms. Perry-Manning reserved judgment on the ultimate merits of the Protest pending a written decision to be issued within ten (10) days of the meeting.

133. Particularly troubling, the Department expressed the concern that correcting errors that would change the outcome of the procurement would potentially require it to re-score all of the Offerors' proposals.

134. The fear of further protests is an improper consideration and another example of the Department abusing its discretion by refusing to properly address on the merits the serious errors and defects identified by Aetna in the scoring of the proposals.

135. The Department instead offered post-hoc rationalizations for the results reached by the Evaluation Committee, ignoring blatantly arbitrary and capricious scores that are unsupported by the evidence and which unfairly prejudiced Aetna.

136. In seeking to immunize the Evaluation Committee's scoring from any scrutiny whatsoever and avoid delays to implementation of the awards irrespective of their merits, the Department abused its discretion and failed to correct the Evaluation Committee's arbitrary and

capricious scoring.

137. Thus, Aetna's Protest was improperly denied, despite the fact that the cumulative effect of the errors and issues identified by Aetna should have not only propelled it into the top four statewide Offerors eligible for a contract award, but into second place.

138. The issues raised by Aetna's Protest and herein are further exacerbated by concerns regarding references made by the Evaluation Committee to making "modifications" to the "criteria/rating definitions," to liberties taken by certain Offerors in ignoring page limits (the full extent of which is not clear due to redactions), and to opportunities given to some, but not all Offerors to provide clarifications to their responses.

139. For the reasons identified herein and to be presented in this Contested Case, the Department's awards, and its failure to correct the errors and defects in those awards in response to Aetna's Protest, are unlawful, unsupported by the evidence, arbitrary and capricious, and the result of an abuse of discretion that should be reversed.

F. The Manipulation of BCBS's Score, Concealment and the Department's Undisclosed and Utter Failure to Avoid Conflicts of Interest.

140. As a result of the production of documents that were improperly withheld in response to public records requests and subsequent deposition testimony, Aetna has further discovered that after the Evaluation Committee's scoring was tabulated and a final summary prepared, Aetna was among the top four PHPs.

141. However, when the Department realized that BCBS was not to receive an award, certain Department officials conspired to manipulate the scoring by creating a new-found "quality assurance" methodology that was not identified in the RFP or, for that matter, anywhere within the Department. The Department's self-created and untimely quality assurance criterion materialized into a self-serving and unprecedented instruction to the Evaluation Committee to

rescore BCBS's proposal in a way that inflates BCBS's score while pushing Aetna out of an award and the opportunity to receive one of the PHP contracts.

142. On December 18, 2018 the Evaluation Committee asked to confer with Lotta Crabtree, a lawyer who had been designated as a subject matter expert (SME) after the evaluation process had commenced, as to whether it was appropriate to score BCBS's proffer of a client reference for "Amerigroup Partnership Plan, LLC subcontract with BlueChoice Health Plan of South Carolina, Inc. (Amerigroup Partnership Plan)" (the "South Carolina Reference").

143. After conferring with Ms. Crabtree on December 18, 2018, the next day, the Evaluation Committee decided to not score the South Carolina Reference − awarding BCBS zero points − because of the lack of a genuinely independent relationship between BlueCross BlueShield of South Carolina and Blue Cross and Blue Shield of North Carolina and its affiliate, Amerigroup Partnership Plan, LLC (for whom the South Carolina Reference had actually been provided).

144. A month later, on January 18, 2019, the Evaluation Committee was provided a summary of the tabulated results of its scoring of the proposals, which revealed that Aetna – and not BCBS – were among the plans to receive awards, based on the following scores:

	Highest Scoring Offer, Ranked 1st	731.99304	71.414%					
					Difference vs Ranked 1st		Difference vs. Next Highest	
	Offeror Name	Weighted Total Score	Percentage of Total Possible Points	Rank	# Points	% Points		
Statewide	WellCare Health Plans	731.99304	71.414%	1	0.00000	0.000%	0.00000	0.000%
Statewide	United Health Care	727.57415	70.983%	2	-4.41889	-0.431%	-4.41889	-0.431%
Statewide	AmeriHealth Caritas North Carolina	711.25579	69.391%	3	-20.73725	-2.023%	-16.31836	-1.592%
Statewide	Aetna	704.60144	68.742%	4	-27.39160	-2.672%	-6.65436	-0.649%
Statewide	BCBSNC – Healthy Blue	700.15931	68.308%	5	-31.83373	-3.106%	-4.44212	-0.433%
Statewide	My Health by Health Providers	629.11280	61.377%	6	-102.88024	-10.037%	-71.04652	-6.931%
Either	Carolina Complete Health	612.64969	59.771%	7	-119.34335	-11.643%	-16.46311	-1.606%
Regional	Optima Health	573.48539	55.950%	8	-158.50765	-15.464%	-39.16430	-3.821%

Total Possible Score	1025.00000
Total Possible If All Scores Meet Expectations (60%)	615.00000

145. Notably, the sanitized "Evaluation Committee Notes and Timeline" (that the Department carefully crafted and revised several times before releasing in public records requests) never makes any mention of the original scoring in which Aetna was in the top four Offerors as represented above, nor did the Department produce the original scoring summary in response to public records requests or discovery requests in these cases until its existence was discovered through depositions and its production demanded.

146. On January 22, 2019, Ms. Crabtree advised the Evaluation Committee that "the relationship between BlueChoice Health Plan and Amerigroup Partnership Plan, LLC and that of Aetna and Mercy Care appeared similar." Irrespective of the fact that Ms. Crabtree's assertion is incorrect, the Evaluation Committee was told to grant BCBS an additional 12.5 points, flipping the results in favor of BCBS. Notably, the sanitized Evaluation Committee Notes and Timelines produced by the Department concealed this change as well.

147. Worse, numerous Department personnel involved in the scoring process and who were involved in this decision specifically have ties to BCBS.

148. Among others, Evaluation Committee scoring member Amanda Van Vleet has been in a long-term relationship and lives with a BCBS employee who serves as the Director, Healthcare Strategy and Transformation for BCBS that works directly with the CEO of BCBS, Patrick Conway MD. Upon information and belief, this employee had previously worked with the CEO of BCBS and another high ranking officer within the Department when they worked in Washington, DC at the CMS Innovation Center. Sarah Gregowski, who designed the RFP, used to work for BCBS before she came to work for the Department. And almost immediately upon completing scoring, Evaluation Committee scoring member Sheila Platts went to work for BCBS after failing to advise the Department of financial issues that were plaguing her and ultimately

caused her to leave the Department for BCBS, where she now works and is being paid more money.

149. In a recent NY Times article published on August 26, 2019 it was reported that:

> "The North Carolina project is the biggest bet yet on the concept. It is being championed by the state's Department of Health and Human Services, which oversees payments for Medicaid, and Blue Cross Blue Shield of North Carolina, the state's largest private insurer. Together, they oversee payments for about two-thirds of the states insured population. That gives them considerable sway over how care is delivered in North Carolina and the leeway to go beyond what has been tried elsewhere. The North Carolina effort is led by two former officials in the Obama administration: Dr. Mandy Cohen, the secretary of the state's health department, and Dr. Patrick Conway..."

150. Dr. Conway is the chief executive of BCBS.

151. This goes far beyond the appearance of impropriety and reflects an utter failure by the Department to uphold the integrity of the evaluation process.

G. The Improper Award of Bonus Points to UHC for Falsely Representing its Ability to Participate in the Federally Facilitated Marketplace.

152. In addition, as identified above, the Department also awarded up to 25 "bonus" points to Offerors who agreed to participate as Qualified Health Plans in North Carolina on the Federally Facilitated Marketplace ("**FFM**"), which Aetna and others objected to during the RFP development process.

153. As revealed by discovery, the Department was highly aware that this would be (correctly) perceived to coerce Offerors to participate in a completely separate program by awarding points that had nothing to do with the ability to serve North Carolina's neediest citizens on Medicaid.

154. But worse, while this litigation was pending, the Department apparently realized for the first time that one of the Offerors – UHC – that had agreed to participate as an Offeror in the FFM was, in fact, legally ineligible to do so under North Carolina law because it had

withdrawn from the FFM marketplace in North Carolina effective January 1, 2017.

155. UHC was thus prohibited from reentering this market for a five-year period pursuant to N.C.G.S. § 58-68-65(c)(2)(b), and its representation that it would participate in the FFM meant that it received an additional 19.10075 points to which it was not entitled.

156. On July 23, 2019, the Department through its legal counsel raised this issue with counsel for UHC, but did not provide at that time a copy of that letter or provide notice of this issue despite longstanding public records and production requests.

157. This issue was first discovered when the Department's July 23 letter was produced on August 19, 2019 as part of an ongoing rolling document production.

158. Not produced at that time was UHC's July 26 response to that letter, which claimed that it planned to comply with its "commitment" by having a separate affiliate participate in the FFM instead of the Offeror. This is nothing more than "spin" and is not reflected or in any way identified in UHC's actual proposal, which committed UHC– not an affiliate – to participate.

159. UHC's July 26 response was finally provided on August 26, 2019, and subsequent deposition testimony confirms that the Evaluation Committee was unaware in scoring proposals that UHC's response to the "bonus" question falsely represented that the "Offeror" was committing to participate in the FFM.

160. Despite this, the Department has communicated that it is satisfied with UHC's July 26 post hoc explanation, allowing it to retain almost 20 points that were awarded under false pretenses. This is yet another example of the Department refusing to take seriously its responsibility to uphold the integrity of the process.

V. CLAIM FOR RELIEF

A. Request for Award of Contract or, in the Alternative, Re-Procurement.

161. Aetna incorporates the foregoing statements and allegations as if fully restated herein.

162. As detailed above, and will be proven at the hearing in this matter, the Department exceeded its authority, acted erroneously, acted arbitrarily and capriciously, used improper procedure and failed to act as required by law as a result of: (1) the Department's manipulation of the scoring process to improperly change BCBS's score after the results were calculated; (2) the Department's disregard for the terms of the RFP and blatant conflicts of interest and an utter failure to safeguard the integrity of the evaluation and scoring process; (3) the Department's acceptance of a false and misleading commitment to directly participate in the Federally Facilitated Marketplace; (4) scoring errors to the unfair prejudice of Aetna that, if corrected, place Aetna in the top three or four statewide Offerors; (5) scoring errors improperly favoring AmeriHealth and BCBS that, if corrected, places Aetna in the top three or four statewide Offerors; and (6) the award of a contract to WellCare based on a materially incomplete and misleading Proposal.

163. The Department's awards and its final decision denying Aetna's Protest should be reversed pursuant to the North Carolina Administrative Procedures Act, which authorizes reversing an agency's decision, where, as here, there is a preponderance of the evidence that the agency either exceeded its authority or jurisdiction; acted erroneously; failed to use proper procedure; acted arbitrarily or capriciously; or failed to act as required by law or rule. N.C. Gen. Stat. §§ 150B-25.1(a), -23(a)

164. The contract awards, and the failure of the Department to correct and address the

issues raised in Aetna's Protest and in this Contested Case, are unsupported by the evidence, arbitrary and capricious, and the result of an abuse of discretion.

165. Under these circumstances, the harm is not just to Aetna, but to the State of North Carolina and its most vulnerable citizens who depend upon Medicaid. Even assuming that the bonus question was properly included in the RFP, which it was not, if the issues raised herein are fully addressed, Aetna is the highest scoring PHP:

Offeror Name	**Corrected Results**
1. Aetna	**723.26219**
2. United Health Care	**708.66399**
3. BCBSNC - Healthy Blue	**699.72431**
4. AmeriHealth Caritas North Carolina	**672.47231**
WellCare Health Plans	Disqualified

166. Accordingly, Aetna is entitled to a determination that it is one of the top four statewide Offerors based upon the necessary correction of scoring errors; and WellCare should be disqualified for its inexcusable omission in failing to properly disclose sanctions and that its Proposal should be rejected pursuant to the RFP.

167. Based on these determinations, Aetna further requests that this Court order the Department to issue a Medicaid managed care contract to Aetna, as it is one of the top four statewide Offerors, pursuant to and in accordance with the terms of the RFP.

168. Alternatively, Aetna requests such other relief as may be necessary to remedy the issues raised in this Contested Case, including, if necessary, re-procurement of the RFP.

169. In addition, the Department has refused to stay the implementation of the awards, despite that continued implementation of the contract awards will cause irreparable injury and harm to Aetna and is against the public interest.

170. Where, as here, it is necessary for the protection of a plaintiff's rights during the

course of litigation, an administrative law judge is authorized to "[s]tay the contested action by the agency pending the outcome of the case, upon such terms as he deems proper, and subject to the provisions of G.S. 1A-1, Rule 65[.]" N.C. Gen. Stat. § 150B-33(b) (6).

171. Aetna has requested that the Department delay contract implementation until its protest and this Contested Case can be decided.

172. Since the filing of this Contested Case, the Department has announced that through no fault of its own the necessary funding legislation for Medicaid transformation has been delayed.

173. Currently, the schedule is such that the transition to managed care will be delayed to February 1, 2020. Open enrollment will be extended until December 13, 2019 and the automatic assignment of beneficiaries to PHP's will begin on December 16, 2019.

174. Aetna has been prevented from engaging in necessary implementation activities. Every day that passes by places Aetna further behind its competitors and those that are less qualified to undertake the managed care in North Carolina for Medicaid beneficiaries.

175. Aetna has no adequate remedy at law and will suffer irreparable injury and harm unless a preliminary injunction is issued restraining the Department, its agents, employees, and representatives and anyone working for it or on its behalf, from further implementing the contract awards until such time as this matter may be heard and decided on the merits.

176. Accordingly, following a hearing on the merits, a declaratory judgment and permanent injunction should be issued: (1) ordering the Department to award to Aetna one of the four statewide contracts under the RFP; and (2) prohibiting the Department from implementing the contract awards until such time that the Department has complied with an order that Aetna be granted a statewide contract pursuant to the RFP, and has further taken any steps necessary to

ensure that Aetna has been fully included in and brought up to date with respect to any implementation steps completed prior to the issuance of injunctive relief.

177. In the alternative, the Tribunal should order that the RFP be re-procured and the current awards vacated because of the unlawfulness, defects, bias, manipulation and arbitrary and capricious actions undertaken by the Department.

This 18th day of September, 2019.

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_____

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CERTIFICATE OF SERVICE

The undersigned certifies that, on the date shown below, I sent the foregoing document to the persons named below at the addresses shown below, by electronic service as defined in 26 NCAC 03.0501(4) and by email, addressed as follows:

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This the 18th day of September, 2019.

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